Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION SURGICAL HOSPITAL
5420 W LOOP SOUTH SUITE 3600
BELLAIRE TX 77401

Carrier's Austin Representative Box
Box Number 15

MFDR Date Received
December 5, 2011

Respondent Name
ACE FIRE UNDERWRITERS INS CO

MFDR Tracking Number
M4-12-1070-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From the Request for Reconsideration Letter dated August 3, 2011:
"We are submitting this claim to you as an APPEAL. Enclosed are the invoice and all medical records needed to complete this claim. Which was original submitted with this claim. Broadside payment on the implants was $12,966.25. The total amount of the implants is $18,780.50. In additional to that payment a 10% mark up is to be paid as well of $1,878.50. We are seeking separate reimbursement on implants. Additional payment will need to be $7,692.75."

Amount in Dispute: $7,692.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: ""The implant invoices were reviewed in combination with the operative report. Per the audit company, several of the invoices did not match the operative report. Additional documentation was requested but not provided. Therefore, the denial stands. The audit company was able to pay for CAP price sys, infuse, and oracle spacer. All other invoices were denied as they were not documented. Until additional documentation is provided to show that all items on the invoices were used during the surgical procedure, additional reimbursement is not owed."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2011 To March 10, 2011	Inpatient Hospital Surgical Services	$7,692.75	$3,727.93

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section,

regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 10, 2011

- 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 5 — The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. $0.00
- 113-012 — OTHER IMPORT RE-PRICING WAS NOT NEGOTIATED
- 649-006 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH SEPARATE ALLOWANCE FOR IMPLANTABLES.
- 670-007 — REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
- 868-999 — INTRA-OPERATIVE NURSING RECORD/IMPLANT RECORD REQUIRED FOR PAYMENT $0.00
- 975-410 — COPY OF PROVIDER'S INVOICE USED TO DETERMINE REIMBURSABLE AMOUNT
- 975-641 — NURSE REVIEW DRG HOSPITAL BILL OR EXEMPT UNIT/FACILITY
- W1 — Workers' Compensation State Fee Schedule Adjustment

Explanation of benefits dated September 12, 2011

- 193 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5 — The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. $0.00
- 649-006 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH SEPARATE ALLOWANCE FOR IMPLANTABLES.
- 670-007 — REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.
- 868-999 — INTRA-OPERATIVE NURSING RECORD/IMPLANT RECORD REQUIRED FOR PAYMENT $0.00
- 900 — BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.
- 975-410 — COPY OF PROVIDER'S INVOICE USED TO DETERMINE REIMBURSABLE AMOUNT
- 975-641 — NURSE REVIEW DRG HOSPITAL BILL OR EXEMPT UNIT/FACILITY
- W1 — Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim

Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. According to the explanation of benefits, the services in dispute were reduced pursuant to a PPO contract as described by Texas Labor Code §413.0115. Texas Labor Code Section §413.011(d-3) states that the division may request copies of each contract under which fees are being paid and goes on the state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On February 17, 2012, the division requested a copy of the contract between the network and the health care provider, and documentation to support that the requestor was notified in accordance with 28 Texas Administrative Code §133.4. The carrier responded to the Division's request to provide a copy of the contract stating, "no PPO contract was utilized and neither was the 45 ANSI code." Consequently, the carrier is required to pay fees in accordance with 28 Texas Administrative Code §134.404 for the services in this dispute.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g).

Description of Implant per Itemized Statement	Quantity	Amt Billed	Invoice Cost	Cost + 10%
LF1 Cap Price Sys	1	$16,000.00	No Invoice Submitted	$0.00
Bone Graft ME Infuse Small	1	$9,804.00	$3,451.00	$3,451.00 + $345.10 = $3,796.10
OR Cancellous Chip Morsel	1	$2,371.50	$4,743.00	$4,743.00 + $474.30 = $5,217.30
SS Graft Delivery Sys	1	$1,980.00	$396.00	$396.00 + $39.60 = $435.60
Sy Orable Spacer	1	$17,346.00	$4,336.50	$4,336.50 + $433.65 = $4,770.15
SS Lum 1 Level BMA Imp	1	$9,000.00	$2,250.00	$2,250.00 + $225.00 = $2,475.00
TOTAL DUE				$16,694.15

4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as

follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 455 is $30,140.58. This amount multiplied by 108% is $32,551.83. The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $15,176.50. The total add-on of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,517.65. The total maximum allowable reimbursement (MAR) is therefore $49,245.98. The respondent previously paid $45,518.05, therefore an additional amount of $3,727.93 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,727.93.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,727.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 13, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.